NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 33

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S33-AMH-14 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
S33-CSTG-1

Date _____,2011

Senator Clodfelter

moves to amend the bill on page 1, lines 9 and 10 by rewriting the lines to read:
"PAYMENT, BY MODIFYING APPEAL BONDS IN MEDICAL MALPRACTICE ACTIONS, BY REFORMING THE PROCESS FOR SETTING HEALTH CARE PROVIDER PROFESSIONAL MALPRACTICE INSURANCE RATES, AND BY REQUIRING ADDITIONAL DISCLOSURES IN MEDICAL MALPRACTICE CLAIM REPORTS AND THAT THE COMMISSIONER OF INSURANCE ANALYZE AND REPORT ON THE CLAIM REPORTS."

and on page 4, line line 38 by inserting the following after that line:

"**SECTION 6.1.** Article 40 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-40-32. Health care provider professional malpractice insurance rates.**

(a) As used in this section:

(1) "Health care provider" has the same meaning as defined in G.S. 90-21.11.

(2) "Insurer" means an insurer or State-chartered risk retention group that provides professional malpractice insurance to health care providers in this State.

(b) No insurer's rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, as defined in G.S. 58-40-20, or otherwise in violation of this Chapter. In considering whether a rate is excessive, inadequate, or unfairly discriminatory, no consideration shall be given to the degree of competition, and the Commissioner shall consider whether the rate mathematically reflects the insurer's investment income.

(c) Every insurer that desires to change any rate shall file a complete rate application with the Commissioner. A complete rate application shall include all data required by G.S. 58-40-30(b) and G.S. 58-41-50, and a detailed description of any experience rating or schedule-rating plan used by the insurer. The application shall also include such other information that the Commissioner requires. The applicant has the burden of proving that the requested rate change is justified and meets the requirements of this Article.

(d) Within 10 days of receiving the rate change application, the Commissioner shall notify the public on the Department's Internet web site of any application by an insurer for a rate change and shall provide written notification of the rate change application to any trade association or organization that represents health care providers and that registers with the Department to receive notification.

(e) The application shall be deemed to be approved 60 days after public notice and written notification under subsection (d) of this section unless any of the following occur:

(1) An insured health care provider, the health care provider's representative, or an association of health care providers, requests a hearing within 30 days after public notice and the Commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision.

(2) The Commissioner on the health care provider's own motion determines to hold a hearing.

(3) The proposed rate adjustment exceeds fifteen percent (15%) of the then-applicable rate, in which case the Commissioner must hold a hearing.

In any event, a rate change application shall be deemed to be approved 120 days after the Commissioner receives the rate application unless that application has been disapproved by a final order of the Commissioner after a hearing. For purposes of this section, "received" means the date delivered to the Department.

(f) The provisions of G.S. 58-40-45 governing the disapproval and interim use of rates shall apply to this section."

SECTION 6.2. G.S. 58-2-170 reads as rewritten:

"**§ 58-2-170. Annual statements by professional liability insurers; medical malpractice claim reports.**

(a) In addition to the financial statements required by G.S. 58-2-165, every insurer, self-insurer, and risk retention group that provides professional liability insurance in the State shall file with the Commissioner, on or before the first day of February in each year, in form and detail as the Commissioner prescribes, a statement showing the items set forth in subsection (b) of this section, as of the preceding 31st day of December. The annual statement shall not be reported or disclosed to the public in a manner or format which identifies or could reasonably be used to identify any individual health care provider or medical center. The statement shall be signed and sworn to by the chief managing agent or officer of the insurer, self-insurer, or risk retention group, before the Commissioner or some officer authorized by law to administer oaths. The Commissioner shall, in December of each year, furnish to each such person that provides professional liability insurance in the State forms for the annual statements. The Commissioner may, for good cause, authorize an extension of the report due date upon written application of any person required to file. An extension is not valid unless the Commissioner's authorization is in writing and signed by the Commissioner or one of his deputies.

(b) The statement required by subsection (a) of this section shall contain:

(1) Number of claims pending at beginning of year;

(2) Number of claims pending at end of year;

(3) Number of claims paid;

(4) Number of claims closed no payment;

(5) Number and amounts of claims in court in which judgment ~~paid:~~ was entered, the amount of the judgment, and the actual amount paid on the

judgment or in settlement of the judgment. For both the amount of the judgment and the actual amount paid, provide the:

a. Highest amount
b. Lowest amount
c. Average amount
d. Median amount;

(6) Number and amounts of claims out of court in which settlement paid:

a. Highest amount
b. Lowest amount
c. Average amount
d. Median amount;

(7) Average amount per claim set up in reserve;
(8) Total premium collection;
(9) Total expenses less reserve expenses; and
(10) Total reserve expenses.

(b1) The Commissioner shall analyze the reports described in subsections (a) and (b) of this section and shall file statistical and other summaries with the General Assembly no later than March 1 of each year. Summaries filed by the Commissioner pursuant to this subsection shall include all of the following:

(1) Any trends noted or observed from the data.
(2) All actions taken by the Commissioner in response to these trends.
(3) Any legislative or other recommendations from the Commissioner with respect to actions by the General Assembly in response to these trends.

(c) Every insurer, self-insurer, and risk retention group that provides professional liability insurance to health care providers in this State shall file, within 90 days following the request of the Commissioner, a report containing information for the purpose of allowing the Commissioner to analyze claims. The report shall be in the form prescribed by the Commissioner. The form prescribed by the Commissioner shall be a form that permits the public inspection, examination, or copying of any information contained in the report: Provided, however, that any data or other characteristics that identify or could be used to identify the names or addresses of the claimants or the names or addresses of the individual health care provider or medical center against whom the claims are or have been asserted or any data that could be used to identify the dollar amounts involved in such claims shall be treated as privileged information and shall not be made available to the public. The Commissioner shall analyze these reports and shall file statistical and other summaries based on these reports with the General Assembly as soon as practicable after receipt of the reports. The Commissioner shall assess a penalty against any person that willfully fails to file a report required by this subsection. Such penalty shall be one thousand dollars ($1,000) for each day after the due date of the report that the person willfully fails to file: Provided, however, the penalty for an individual who self insures shall be two hundred dollars ($200.00) for each day after the due date of the report that the person willfully fails to file: Provided, however, that upon the failure of a person to file the report as required by this subsection, the Commissioner shall send by certified mail, return receipt requested, a notice to that person informing him that

he has 10 business days after receipt of the notice to either request an extension of time or file the report. The Commissioner may, for good cause, authorize an extension of the report due date upon written application of any person required to file. An extension is not valid unless the Commissioner's authorization is in writing and signed by the Commissioner or one of his deputies.

(d) Every person that self-insures against professional liability in this State shall provide the Commissioner with written notice of such self-insurance, which notice shall include the name and address of the person self-insuring. This notice shall be filed with the Commissioner each year for the purpose of apprising the Commissioner of the number and locations of persons that self-insure against professional liability."

SECTION 6.3. G.S. 58-40-25 reads as rewritten:

"**§ 58-40-25. Rating methods.**

In determining whether rates comply with the standards under G.S. 58-40-20, the following criteria shall be applied:

(1) Due consideration shall be given to past and prospective loss and expense experience within this State, to catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to trends within this State, to dividends or savings to be allowed or returned by insurers to their policyholders, members, or subscribers, and to all other relevant factors, including judgment factors; however, regional or countrywide expense or loss experience and other regional or countrywide data may be considered only when credible North Carolina expense or loss experience or other data is not available.

(1a) Notwithstanding the provisions of subdivision (1) of this section, an insurer or State-chartered risk retention group that provides professional malpractice insurance to health care providers, as defined in G.S. 90-21.11, may use regional or countrywide expense or loss experience and other regional or countrywide data only upon written approval by the Commissioner. The Commissioner may approve the use of regional or countrywide data only upon a finding of good cause.

(2) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Those standards may measure any differences among risks that have probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations. Those classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions.

(3) The expense provisions included in the rates to be used by an insurer may reflect the operating methods of the insurer and, as far as it is credible, its own expense experience.

(4) In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Planning Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____